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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **ARLENE RELLOMA** **AKA ARLENE RAYCO RELLOMA** **1565 Beach Park Boulevard** **Foster City, CA 94404** **Registered Nurse License No. 641104** Respondent.	Case No. 2013-844 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about June 23, 2004, the Board of Registered Nursing issued Registered Nurse License Number 641104 to Arlene Relloma, aka Arlene Rayco Relloma ("Respondent"). The Registered Nurse License was in full force and effect at all times relevant to the charges brought herein and will expire on June 30, 2014, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing ("Board"),

Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

5. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

6. Section 118, subdivision (b), of the Code provides that the suspension/expiration/surrender/cancellation of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary action during the period within which the license may be renewed, restored, reissued or reinstated.

RELEVANT DISCIPLINARY STATUTES AND REGULATIONS

7. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . ."

8. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

COST RECOVERY

9. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case, with failure of the licentiate to comply subjecting the license to not being renewed or reinstated. If a case settles, recovery of investigation and enforcement costs may be included in a stipulated settlement.

STATEMENT OF FACTS

10. Respondent at all relevant dates was employed as a labor and delivery nurse at Washington Hospital HealthCare System ("WHHS") in Fremont, California.

11. On May 27, 2010 at 4:40 a.m., Patient 1 was admitted in active labor with a term pregnancy. Respondent assumed care of Patient 1 and placed her on an electronic fetal heart rate ("FHR") monitor. At approximately 5:00 a.m., Respondent documented that the FHR variability was minimal to moderate, without accelerations. There was no documentation regarding the baseline FHR and the presence and/or absence of decelerations.[1]

12. At approximately 5:05 a.m., Respondent telephoned Patient 1's physician, Dr. A.M. and informed her that "FHR on admission 140's, but at 115 at this time, no accels (accelerations) noted, tracing at this point can't be confirmed as decel (deceleration) or change in baseline as baseline is not yet established; with minimal to moderate variability."[2] Dr. A.M. denied that Respondent reported any concerns with the FHR tracing. Admission orders included continuous FHR monitoring and an epidural for pain relief. No interventions were taken by Respondent in response to Patient 1's abnormal FHR tracing.

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[1] WHHS Fetal Heart Rate Monitoring Protocol required that the FHR in a low risk patient be auscultated every 30 minutes during the active phase of labor. This assessment was to include documentation of the baseline FHR, variability; presence or absence of accelerations and/or decelerations.

[2] WHHS Fetal Heart Rate Monitoring Protocol defined a "high-risk" FHR as one that demonstrated absent or minimal variability, recurrent late or variable decelerations, and/or persistent tachycardia or bradycardia. Various interventions are to be taken by nursing staff which include notification of the patient's physician.

13. From approximately 5:14 a.m., to 6:04 a.m., Respondent was on break. Registered Nurse Audrey Keenan ("Keenan"), assumed care of Patient 1. Prior to leaving, Respondent told Keenan that Patient 1 was to get an epidural. No mention was made of the FHR tracing. [3]

14. The last recorded FHR of Patient 1's fetus was at 5:29 a.m., which reflected a heart rate between 100 to 110 beats per minute, with minimal variability and late decelerations.

15. At 5:30 a.m., the anesthesiologist was in Patient 1's room, with placement of the epidural completed at 5:53 a.m.[4]

16. Respondent returned from her break at 6:04 a.m., and went into Patient 1's room. Keenan was in the room and had just placed a fetal scalp electrode ("FSE") in an attempt to locate the FHR.[5] This was unsuccessful. At 6:07 a.m., Respondent attempted to locate the FHR by adjustment of the external monitor and then placed a second FSE at 6:12 a.m. No fetal heart rate was detected. The charge nurse arrived in the room at 6:14 a.m., and applied a third FSE and instructed Keenan to call Patient 1's physician.

17. At approximately 6:15 a.m., Dr. A.M. was called at home and advised that the nursing staff was unable to find the FHR on Patient 1. The in-house hospitalist, Dr. R.F. arrived in Patient 1's room at 6:17 a.m. A bedside abdominal ultrasound was performed and showed no fetal heart activity with the diagnosis of an intrapartum fetal demise.

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[3] WHHS protocols require staff use "**SBAR**" for hand-off communications to ensure that accurate information is provided about a patient's care, treatment and service, current condition and any recent or anticipated change. SBAR is a communication approach that includes the following: **S**ituation, **B**ackground, **A**ssessment and **R**ecommendation regarding the patient's condition.

[4] WHHS's epidural protocol requires that there be continuous FHR monitoring during the procedure with documentation of the baseline FHR and variability.

[5] A fetal scalp electrode is a method of directly monitoring the FHR by attaching an electrode to the fetal scalp.

FIRST CAUSE FOR DISCIPLINE

(Gross Negligence – Failure to Perform Complete Assessment of FHR)

18. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), for gross negligence in that she failed to completely interpret the FHR tracing on admission in that she omitted documentation regarding the baseline FHR and as to the presence and/or absence of decelerations. The facts in support of this cause for discipline are set forth above in paragraphs 10 through 12.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence – Failure to Intervene In the Presence of Abnormal FHR Tracing)

19. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), for gross negligence in that she failed to intervene when Patient 1 presented to WHHS with an abnormal FHR tracing. The facts in support of this cause for discipline are set forth above in paragraphs 10 through 12.

THIRD CAUSE FOR DISCIPLINE

(Gross Negligence-Failure to Notify Physician of Non-Reassuring FHR Tracing)

20. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), for gross negligence in that she failed to notify Patient 1's physician of the abnormal FHR tracing on admission. The facts in support of this cause for discipline are set forth above in paragraphs 10 through 12.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence-Failure to Give Complete Report To Relief Nurse)

21. Respondent is subject to disciplinary action under Code section 2761, subdivision (a)(1), for gross negligence in that she failed to provide the relief nurse with a full report on Patient 1's condition and the FHR tracing. The facts in support of this cause for discipline are set forth above in paragraph 13.

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FIFTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct - Failure to Timely Summon Medical Assistance)

22. Respondent is subject to disciplinary action under Code section 2761, subdivision (a), for unprofessional conduct in that she failed to timely summon medical assistance when the FHR was unable to be detected at 6:04 a.m. The facts in support of this cause for discipline are set forth above in paragraphs 16 and 17.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License Number 641104, issued to Arlene Relloma, aka Arlene Rayco Relloma;

2. Ordering Arlene Relloma, aka Arlene Rayco Relloma to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: MARCH 28, 2013

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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